SIR,—Dr. J. W. D. Bull, in his masterly and authoritative Langdon Brown lecture (10 August, p. 394), while rightly paying tribute to the outstanding contribution of radiology in the fields of anatomy and clinical medicine, nevertheless feels bound, once again, to highlight his specialty's overall pitiful and desperate state in this country. One hopes that his appeal for an eminent committee of investigation will be taken up speedily and effectively and not allowed, by prolonged labour, to beget yet another report destined merely for dust collection on impotent academic shelves.

Of the several necessary remedies proposed by Dr. Bull, the need to stimulate radiological interest early in medical careers is clearly of great importance. I believe that the sparks of this interest can be kindled even earlier—that is to say, in schools. An illustrated talk to career-minded youngsters can be an unforgettable experience for both speaker and audience. Röntgen, the exciting discovery of x-rays, some properties of x-rays, how patients are radiographed in hospitals, how bones grow, fractures, pregnancies, foreign bodies, the alimentary, urinary, and biliary systems, animal x-rays, x-rays in archaeology and art—these are some of the topics which invariably set young receptive minds agog with intense fascination. The radiological seed, one feels, can be planted very early and this could be organized on a national scale. Can our medical schools foster its germination? Hopefully, Dr. Oscar Craig has pointed the way.—I am, etc.,

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Aetiology and Treatment of Gastric Ulcer

SIR,—Perhaps the most interesting aspect of gastric surgery today is the aetiology of lesser curve gastric ulcer. Two facts are clearly established. The high incidence of gastric retention in this disease has been repeatedly documented in the past and the frequency of pyloric reflux in gastric ulceration is well established.

Magnus¹ and others long ago showed that all patients with lesser curve gastric ulcer, no matter how high the lesion, have prepyloric disease (pyloroantritis), and Schrager *et al.*² found that pyloroantritis was never present without duodenitis. No wonder then that Konjetzny³ used the term gastroduodenitis. Many workers earlier in this century described in detail the morbid anatomy and the light microscopy of this pyloroantritis. Indeed, Ross Golden⁴ tells us that Holsti reported pathological change in the nerve cells of the intramural plexus. Du Plessis⁵ confirmed this distal gastric disease in patients with gastric ulcer, and more recently Liebermann-Meffert and Allgöwer⁶ have done the same in Basle.

I think we find the true explanation of pyloric reflux in gastric ulceration when our thoughts turn to the heart. Mitral or aortic regurgitation exists only because of disease of the valves and their neighbouring structures, and this disease can produce reflux (regurgitation) and stenosis in the same patient. Have we not then an exact parallel in pyloroduodenal disease? As in the heart, pyloric reflux in patients with gastric ulceration would seem to be secondary to

the duodenopyloroantral disease we know is always present. Since 1962 I have believed that lesser curve gastric ulcer is caused by gastric retention secondary to this distal duodenopyloroantritis⁷ and not to the reflux it produces. Vagotomy cures this distal disease.

This hypothesis, therefore, leads directly to proximal gastric vagotomy without drainage as the operation of choice for all gastric ulcers. The work of Johnston in Leeds⁸ and myself in London, covering as it does jointly some 100 cases for a period of five years, leaves little doubt that proximal gastric vagotomy without drainage and not Billroth I gastrectomy should be the routine surgical treatment for gastric ulcer.—I am, etc.,

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- 1 Magnus, H. A., *Modern Trends in Gastroenterology*, ed. F. Avery Jones. London, Butterworth, 1952.
- 2 Schrager, J., Spink, R., and Mitre, S., *Gut*, 1967, 8, 497.
- 3 Konjetzny, G. E., *Wiener Klinische Wochenschrift*, 1933, 46, 451.
- 4 Golden, R., *Diagnostic Roentgenology*, vol. 1, p. 285. London, Nelson, 1941.
- 5 Du Plessis, D. J., *South African Medical Journal*, 1969, 43, 1076.
- 6 Liebermann-Meffert, D., and Allgöwer, M., *Archives Francaises des Maladies de l'Appareil Digestif*, 1972, 61, 284c.
- 7 Burge, H., *Vagotomy*. London, Arnold, 1964.
- 8 Johnston, D., Leeds General Infirmary. Personal communication.

Age Limit for Contraceptives

SIR,—Please allow me to correct the erroneous impressions given by Dr. Elizabeth M. Elliott in her letters (27 July, p. 260, and 31 August, p. 574).

As Dr. Elliott well knows, all Family Planning Association doctors have a local group, which sends a representative to the Clinic Doctors' National Council, meeting at least once a year to consider all matters relating to medical policy and clinical practice and also to debate resolutions sent up from local groups. A smaller executive committee appointed by this council meets as often as needed and at least twice yearly. As chairman of her local group, Dr. Elliott can call meetings of her colleagues at any time. She need not invite her branch administrator or any other lay person to these meetings. My own doctors' group (branch 17) never had any non-medical person present at our meetings, and we held "free discussion which could include criticism of F.P.A. policy." The representative on the Doctors' National Council from Dr. Elliott's East Anglian group also serves on the executive and is therefore particularly well placed to put forward resolutions for consideration by F.P.A. doctors. The fact that no resolutions on the very many matters which so concern Dr. Elliott have been presented to the council or the executive suggests that Dr. Elliott does not have the support of the F.P.A. doctors in East Anglia.

Finally, let me reassure the readers of your columns about the responsible and ethical behaviour of their colleagues working in family planning clinics. We are all as concerned as Dr. Elliott about the well-being, physical, emotional, and social, of our patients of any age. On the rare occasions when contraceptive advice has been given to children below the age of 16 in my own

clinic it has been to children already sexually active, usually in the weeks following an abortion or full-term pregnancy, and not only with the consent, but at the urgent request, of parent or guardian.—I am, etc.,

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Streptokinase Therapy and Cavernous Sinus Thrombosis

SIR,—Cavernous sinus thrombosis is, fortunately, rarely encountered nowadays. When it is, however, the traditional antibiotic therapy may usefully be reinforced by a course of thrombolytic therapy, especially if diagnosed early.

A 73-year-old man presented with a 36-hour history of gross bilateral orbital oedema, proptosis, and chemosis. There was marked periorbital swelling and two septic lesions of the upper lip, which yielded group A haemolytic streptococci on culture. He was treated with penicillin and a four-day course of intravenous streptokinase. This brought about a remarkable recovery, the oedema subsiding in 48 hours, his eyes opening, and vision returning after one week. There were no initial or residual cranial nerve signs.

The patient's admission was prolonged for social reasons, and one month later he developed a dense left hemiplegia from which he died. Post-mortem examination showed a small thrombus remnant in the right cavernous sinus and some old thrombosis of the left sinus. No pus was found in either orbit.

There have been very few reports of successful thrombolytic therapy in intracranial venous thrombosis.¹ The difficulty of early diagnosis makes it unlikely that thrombolytic therapy can be commenced shortly after thrombus formation. Some workers² advocate that thrombolysis is better reserved for aseptic cases.—I am, etc.,

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- 1 Schöll, H., and Schaub, R., *Deutsche medizinische Wochenschrift*, 1968, 93, 2516.
- 2 Friedmann, G., Huhn, A., and Loo, J.v.de, *Radiologie*, 1971, 11, 424.

Malaria in Birmingham 1968-73

SIR,—The article by Dr. V. E. Ansdell and others (27 April, p. 206) seems to fail to make clear the purpose and limitations of continuing drug prophylaxis after leaving a malaria endemic area. It refers to continuing prophylaxis for "the required four to six weeks after returning home" but does not explicitly state what this may and may not achieve.

Continuing to take a suitable prophylactic for this length of time may be expected to eradicate any malignant tertian parasites; it in no way guarantees eradication of vivax, malariae, or ovale parasites, which may cause malaria months or years later, as in the three patients quoted who did continue their prophylaxis. Eradication of these parasites requires a course of primaquine after leaving the area, as given to 38 patients in the report.

There is no inaccuracy in the article, but this important point is not brought out with any clarity.—I am, etc.,

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